CENTERS FOR MEDICARE & MEDICAID SERVICES

10/06/2011 PRINTED: FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER:	(X2) MUI	LTIPLE CO	NSTRUCTION 00	(X3) DATE S COMPL		
THIS TEAT	or condition	15G272	A. BUILI			09/16/2		
			B. WING		DDRESS, CITY, STATE, ZIP CODE			
NAME OF PROVIDER OR SUPPLIER				723 N 2				
IN-PACT INC			VALPARAISO, IN46383					
(X4) ID				ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCI)		DATE	
W0000								
			W ₀	000		•		
	This visit was for the #IN00096221.	e investigation of complaint						
	COMPLAINT #IN0	0096221:						
		al/State deficiencies related to						
	the allegation are cit	ted at W149 and W288.						
	Dates of Survey: Se	eptember 14, 15, and 16, 2011.						
	Facility number: 00	0792						
	Provider number: 1							
	AIM number: 1002	49020						
	Surveyor: Tim Sheb III-Team Leader	pel, Medical Surveyor						
	state findings in acco	al deficiencies also reflect ordance with 431 IAC 1.1. apleted 9/22/11 by Ruth al Surveyor III.						
W0149	written policies and mistreatment, negleber Based on record facility neglected abuse/neglect policies.	licy to assure 1 of 1 client one staffing (client C)	W0	149	W 149Staff #7 received a disciplinary action for not following the 1:1 staffing for C. Responsible person: Samantha Baker, Club Hous Supervisor. Staff #7 recieve training on the staff to consuratio. Responsible person:	e d mer	10/16/2011	
	Findings include	:			Samantha Baker, Club Hous Supervisor. All staff recieved			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

34CW11

Facility ID:

000792

If continuation sheet

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED	
		15G272	B. WING			09/16/2011	
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER				723 N 2			
IN-PACT INC					RAISO, IN46383		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	1	ID			(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION	
TAG		GULATORY OR LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)		DATE
	The facility's rece 9/14/11 at 11:04 incident reports indicated the foll C], Date: 8/31/20 incident occurred Narrative: This [Client T] (Unknown program). [Client Toom playing with consumer. Also [Client C], howe one staff (one stath ad left the room unsupervised. [Client retrieved his glast C] to the closest staff (staff #7) re [Client T] report (staff #7.) Plant #7) has been sus outcome of an in since a one on on was left unsupermonitored for signature of 1/14/11 at 11:15 the investigation 8/31/11 incident,	ords were reviewed on A.M The review of from 3/1/11 to 9/14/11 lowing: "Name: [Client 011, Location: (where d) Day Program, incident was reported by fown client attending day nown client attending day nown client attending day nown the game of the Wii with another in the game room was ever his (Client C's) one to aff to supervise one client) in leaving [Client C] Client C] stood up and to the triangle of the companion of the start of the room, where the incident to staff to Resolve: Staff (staff pended pending the evestigation of neglect the consumer (Client C) wised. [Client T] will be			training on what to do/how to handle if staff's attention is deverted or if staff have to us the restroom. Responsible person: Samantha Baker, Cli House Supervisor. A protocol developed for client C on 1:1 staffing. Responsible person: Traci Hardesty, QMF staff recieved training on Clie C's protocol. Responsible per Samantha Baker, Club Hous Supervisor. To ensure future compliance, a day service cowill be made at least monthly. Responsible person: Peggy Buchanan, Gi Home Manager & Traci Hard QMRP.	se ub was RP.All ent rson: e	

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G272	(X2) MU A. BUIL B. WING	DING	00	(X3) DATE COMPL	ETED	
NAME OF PROVIDER OR SUPPLIER IN-PACT INC			STREET ADDRESS, CITY, STATE, ZIP CODE 723 N 200 E VALPARAISO, IN46383					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.ΤΕ	(X5) COMPLETION DATE	
	received discipling further indicated action was a write counseling, and none on one proto abuse/neglect po	d and the staff (staff #7) nary action." The review staff #7's disciplinary tten/verbal warning, retraining on client C's scol and the facility's licy. rning Program Supervisor						
	was interviewed A.M Commun. Supervisor stated written up and giretrained on [clie program. [Clien one on one (with staff working wiprogram) are trained on one and rethem all of the tido not occur. In one on one staff, should occur with terminated. It we	on 9/15/11 at 10:38 ity Learning Program d, "Staff (staff #7) was iven a verbal warning and						
	Day Services Ma on 9/15/11 at 10: Manager stated, staff (staff #7) to unsupervised."	anager was interviewed 47 A.M Day Services "It was neglect for the leave (Client C) ords were further						
		5/11 at 2:11 P.M A						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

34CW11 Facility ID:

000792

If continuation sheet

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STATEMENT OF DEFICIENCIES		IDENTIFICATION NUMBER:		(x2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION								
		15G272	B. WINC			09/16/2	011	
NAME OF PROVIDER OR SUPPLIER					DDRESS, CITY, STATE, ZIP CODE			
IN-PACT INC				723 N 20	00 E RAISO, IN46383			
					(AISO, IN40303			
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		,	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION	
TAG			'	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	DATE		
1/10	review of the fac	· · · · · · · · · · · · · · · · · · ·		I/IG	·		DATE	
		vestigating Incidents and						
		• •						
	_	buse and Neglect", no						
		part the following: "b.						
	_	es failure to provide						
		food, medical care or						
	supervision."							
	This C. 1	-1-4414						
	This federal tag relates to complaint #IN00096221. 1.1-3-2(a)							
W0288	Techniques to manage inappropriate client behavior must never be used as a substitute for an active treatment program.							
		. 0	W()288	W288Staff #7 received a		10/16/2011	
	Rased on record rev	iew and interview, the facility			disciplinary action for not			
	Based on record review and interview, the facility failed to address one on one staffing in an active				following the 1:1 staffing for of C. Responsible person:	client		
		or 1 of 1 client receiving one			Samantha Baker, Club Hous	e		
	on one staffing (clie	nt C.)			Supervisor. Staff #7 recieved			
					training on the staff to consul	mer		
	Findings include:				ratio. Responsible person:			
	The facility's record	s were reviewed on 9/14/11 at			Samantha Baker, Club Hous Supervisor. All staff recieved			
	_	view of incident reports from			training on what to do/how to			
		dicated the following: "Name:			handle if staff's attention is			
		31/2011, Location: (where			deverted or if staff have to us	se l		
	incident occurred) Day Program, Narrative: This incident was reported by [Client T] (Unknown client attending day program). [Client T] was in				the restroom. Responsible person: Samantha Baker, Cli	uh		
					House Supervisor. A protocol			
		ing with the Wii with another			developed for client C on 1:1			
		he game room was [Client C],			staffing for active			
	however his (Client	C's) one to one staff (one staff			treatment. Responsible			

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Event ID: 34CW11 Facility ID:

000792

If continuation sheet

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
15G272		15G272	B. WIN			09/16/2	011
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER							
IN-PACT INC			723 N 200 E VALPARAISO, IN46383				
					(Aloo, 114-0000		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
		ent) had left the room leaving			person: Traci Hardesty, QMF		
		rised. [Client C] stood up and			staff recieved training on Client		
		's] glasses and scratched			C's protocol. Responsible pe Samantha Baker, Club Hous		
		lient T] retrieved his glasses			Supervisor. To ensure future	C	
	_	[Staff #7] returned to the room,			compliance, a day service co	ntact	
		the incident to staff (staff #7.)			will be made at least		
		aff (staff #7) has been			monthly. Responsible		
		the outcome of an investigation			person: Peggy Buchanan, G		
		ne on one consumer (Client C)			Home Manager & Traci Hard	esty,	
	was left unsupervise	ed. [Client T] will be			QMRP.		
	monitored for signs	of infection."					
		ger was interviewed on 9/15/11					
		Services Manager stated client					
		g one on one staff supervision					
	for "at least six mor	iths."					
	Client C's record w	as reviewed on 9/15/11 at					
		ew of the client's 6/15/11					
		lan did not indicate one on one					
		as included in the plan. A					
		s "one on one staffing					
		1 defined Client C's one on					
	_	uirements and how staff were					
	to implement the cli	ient's one on one.					
	QMRP (Qualified N						
	,	s interviewed on 9/15/11 at					
	*	P#1 stated Client C had been					
		e staffing at day program "for					
		MRP #1 further stated Client					
		ffing protocol was not included					
	8/31/11 incident."	nt program "until after the					
	6/31/11 metaent.						
	This federal tag rela	ates to complaint					
	#IN00096221.	to complaint					
	1.1-3-5(a)						
	, ,						

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/06/2011 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDEN		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G272	(X2) MULTIPLE CC A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/16/2011		
		190272	B. WING	ADDRESS, CITY, STATE, ZIP CODE	09/10/2011		
NAME OF PROVIDER OR SUPPLIER			723 N 200 E				
IN-PACT INC			VALPA	RAISO, IN46383			
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)		
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE COMPLETION DATE		